No. 99-1815

In the Supreme Court of the United States

NATIONAL LABOR RELATIONS BOARD., PETITIONER

v.

KENTUCKY RIVER COMMUNITY CARE, INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED MAY 12, 2000
CERTIORARI GRANTED SEPTEMBER 26, 2000

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BEFORE THE NATIONAL LABOR
RELATIONS BOARD

Case 9-RC-16837

IN THE MATTER OF
KENTUCKY RIVER COMMUNITY CARE, EMPLOYER

AND

KENTUCKY STATE DISTRICT COUNCIL OF
CARPENTERS, UNITED BROTHERHOOD OF
CARPENTERS AND JOINERS OF AMERICA,
AFL-CIO, PETITIONER

DOCKET ENTRIES

DATE	DOCKET ENTRY
1/27/97	Representation petition filed
2/10/97	Hearing opened
2/11/97	Hearing closed
2/21/97	Decision and direction of election filed
3/6/97	Respondent's request for review filed
3/21/97	Board's order denying review filed
4/7/97	Certification of Representative filed

BEFORE THE NATIONAL LABOR
RELATIONS BOARD

Case 9-CA-34926

KENTUCKY RIVER COMMUNITY CARE, INC.,
AND KENTUCKY STATE DISTRICT COUNCIL OF
CARPENTERS, AFL-CIO,UNITED BROTHERHOOD OF
CARPENTERS AND JOINERS OF AMERICA,
AFL-CIO, PETITIONER

DOCKET ENTRIES

DATE	DOCKET ENTRY
5/20/97	Unfair labor practice charge filed
5/22/97	Complaint and notice of hearing filed
6/4/97	Answer filed
7/10/97	Board's decision and order filed

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Nos. 97-5885, 97-5983

KENTUCKY RIVER COMMUNITY CARE, INC.,
PETITIONER/CROSS-RESPONDENT

v.

NATIONAL LABOR RELATIONS BOARD,
RESPONDENT/CROSS-PETITIONER

KENTUCKY STATE DISTRICT COUNCIL
OF CARPENTERS, AFL-CIO, INTERVENOR

DOCKET ENTRIES

DATE	DOCKET ENTRY
7/17/97	Petition for review filed
8/11/97	Cross-application for enforcement filed
8/29/97	Response to application for enforcement filed
10/4/99	Decision of the court of appeals filed

DATE	DOCKET ENTRY
1/27/00	Judgment of the court of appeals entered
2/24/00	Petition for rehearing with suggestion for rehearing en banc filed
3/16/00	Motion to consider new evidence filed
3/23/00	Petition for rehearing with suggestion for rehearing en banc and motion to consider new evidence denied
3/31/00	Mandate of court of appeals issued

NATIONAL LABOR RELATIONS BOARD

Case No. 9-RC-16837

IN THE MATTER OF
KENTUCKY RIVER COMMUNITY CARE, EMPLOYER

AND

KENTUCKY STATE DISTRICT COUNCIL OF CARPENTERS, UNITED BROTHERHOOD OF CARPENTERS AND JOINERS OF AMERICA, AFL-CIO, PETITIONER

PROCEEDINGS

February 11, 1997 9:05 a.m.
Morning Session

HEARING OFFICER MORTON: On the record. Mr. Miller, would you like to call your next witness. And the witness today, will be over here, rather than over there.

MR. MILLER: We'd call Leonard Echols.

HEARING OFFICER MORTON: Mr. Echols. Raise your right hand.

WHEREUPON,

LEONARD ECHOLS,

A witness herein, after being first duly cautioned and sworn, was examined and testified as follows:

HEARING OFFICER MORTON: Okay, Go ahead, Mr. Miller.

DIRECT EXAMINATION

BY MR. MILLER:

Q. Can you hear me all right?

A. Uh-huh.

Q. What is your name?

A. Leonard Echols.

Q. Mr. Echols, where are you employed?

A. Caney Creek Rehabilitation Complex.

Q. Where is that?

A. It's in Pippa Passes, Kentucky.

Q. What position do you hold there?

A. I'm the Administrator.

Q. And, as Administrator, what are your responsibilities?

A. To monitor and direct the operation of that facility, as far as the utilization of the budget re-

sources, the staffing, training, interface with the community and other agencies.

Q. Could you tell us, briefly, what that facility's function is?

A. It's an 80-bed psychiatric rehabilitation program that houses chronically mentally ill adults, primarily from the State Psychiatric System, where people have history of or histories of being in State Psychiatric Hospitals.

It provides a method of treatment based on psychiatric rehabilitation, which is out of Boston University, which helps people develop skills and whatever they need to be able to move ahead with their life, to possibly move into the community, become independent or semi-independent.

Uh—often dealing with the fact that they have been institutionalized for long periods of time and simply either have not learned the skills initially or have lost those skills because of no need to use them.

So, it's an activity-based program, where individual plans are developed with each resident to try to determine what it is that they want to accomplish, and then how to go about accomplishing that.

And then there are different experiential opportunities set up between the educational groups, life skills groups, to help them attain whatever that goal is.

Q. Okay. Thank you. How many employees work at this facility?

A. I believe there are 110 at this point.

Q. Now you mentioned, a minute ago, treatment plans for the residents. First of all, how many residents do you currently have?

A. Seventy-five.

* * * * *

Q. And then how the—how the—you relate to the unit coordinators and rehab counselors and so forth?

A. There is—the administrative position, the one that I hold. There's also an assistant administrator for operations that is responsible for such things as overseeing maintenance and housekeeping and the clerical staff.

On the clinical side, or the treatment side, there is a clinical coordinator position which is currently vacant, and then two unit coordinators that are the team leaders for two units, one half of the building each.

On each unit–by the way, the building is divided into four equal 20-bed units. They're all identically made up. Each unit has five rehab counselors and ten rehab assistants. There's also additional nursing staff, the six RN's and LPN's that provide medical service and deal with providing medications, since

most of—all of our residents are on sometimes very complicated medications.

* * * * *

Q. Now, in addition to orientation does the treatment plan have any other elements or parts?

A. Well, again, depending on the individual need of the resident, it may have including anything from participation in specific groups, for example, if you have a person that you are—who has decided that they want to live independently, and that's an appropriate goal for them, you would get them involved in things like anything from money management to medication, understanding their medication, eventually to be self-medicated.

To be able to go out and shop. To handle, just sort of the day-to-day routines that most of us take for granted, but they have not had much experience with.

With other people, again, it may be just helping them develop what we call their general life skills or their daily life—uh, their ADL's is what it's called, that's basically their life skills, how to get up, get going, get dressed, attend meetings or—or be at breakfast on time, that sort of thing.

So the range of that, of what the plan may be, again, is quite wide. And it's related to the ability of that particular resident to what their functioning level is and also what their goal is.

We've had situations of people that came in, we thought would be rather limited, and it's turned out they've—they have managed to move ahead quite far. We have had other people that are really clearly fairly restricted in how far they'll go. And so the rehabilitation of that person is primarily to help them get the most out of the program.

They probably will stay there indefinitely, as opposed to other people who have moved out and into the community successfully.

Q. So you have residents who have a quite wide range in degrees—

A. That's correct.

Q. —of ability to function?

A. That's correct.

Q. Now, these other aspects of the treatment plan, who is responsible for developing those?

A. Those are all part of—I mean the—the groups are developed as part of the overall program. And an individual resident will not be in all groups. In other words that might not meet their needs.

So the plan determines which groups or which activities they should—they should participate in.

Q. And if—

A. It's kind of a menu approach to—to that.

Q. And who's responsible for developing the treatment plan?

A. The rehab counselor.

Q. Does that—is that plan in writing?

A. Yes. There's a format that's set up that's very similar to the medical records that you would find in most—in any residential or hospital setting. And those are regulated as to what needs to be included in those plans, as far as demographic information as well as goals and objectives.

Q. Does the plan have to be modified at all during the course of the resident's stay?

A. There are—there are—first of all, there has to be reviewed at least every 30 days. But in addition to that, they do—they do a weekly summary that essentially reviews whether there's been any progress or changes in what's going on with that particular resident.

Those summaries should relate back to the actual goals in the treatment plan. Uh—if there's been anything unusual or unique, that's occurred during the week, that will be, of course, entered into the record, at the point that that occurs.

But they are required to do weekly summaries, and then a monthly.

Q. Is the treatment plan and these summaries and weekly updates are they in writing?

A. Yes.

Q. Who prepares those?

A. The counselor. Other people may participate, by the way, in the summary, other—other members of the treatment team may participate, because there are observations made by nursing or assistants or even you could have information from people in the kitchen or—or maintenance, if they've had some interaction. So any of that information can be included. It may come from other staff.

* * * * *

Q. Do they—do they have—who do the rehab counselors report to, if anybody?

A. The unit coordinator.

* * * * *

Q. In sharing of this information, if there's some decision that has to be made about what to do with respect to a resident, who would make—who would be responsible for making that decision?

A. The modification of the treatment plan is the counselors responsibility. And that—and that again is signed off on by the unit coordinator.

* * * * *

Q. Since you've touched on it now, can you describe the duties of the rehab assistants, what they do?

A. Well I think they're—they're pretty much like the traditional direct care staff in any kind of residential or inpatient. They provide, as I've—the two terms, I think, are support and supervision, that they're the—they're the largest part of the manpower that's there.

And they do most of the—the real basic kinds of work, and make sure the people get up in the morning, get to where they need to be going, to make sure they are where they're supposed to be.

You pretty much live and die on the basis of structure and schedules, because we're responsible for these people. We need to make sure that they're not either wandering around or that they're not spending a lot of time not participating in the program.

* * * * *

Q. By the way, once the case treatment plan is prepared, where is that filed?

A. It's in medical records. There's a record on each resident. That includes all of the required information—uh, and those are at the work stations.

Q. Those are at the work stations?

A. There's a work station between each of the two units. So there's—there's a work station for each side of the building. And the medical records are kept there.

* * * * *

Q. If a rehab assistant has some question about what to do about—with respect to a particular resident, you know, what would he or she do to find out what to do?

A. Well it would depend on what the—what the level of the question was. It might be they'd just ask the counselor or the unit coordinator. And sometimes they can just ask each other if they're just not clear about how something has been—has been communicated.

* * * * *

Q. If a rehabilitation assistant did something that was serious and the question of discipline came up, such as a written warning or something more serious, how would that process work?

A. Well usually the—whatever the incident was, would be documented on the unusual incident report. And then that comes up to me, would be shared with the unit coordinator, whatever form of investigation or substantiation needs to be done would be carried out.

And if, in fact, it required an action, that would be carried out generally by the supervisor, which—which in this case the unit coordinator would actually carry out.

Q. Okay. Now if this—if it was a situation which the rehabilitation counselor was first made aware of,

would the counselor have any responsibilities concerning communicating that incident to yourself or the unit coordinator?

A. Whoever is aware of the incident is required to document, that's standard for all staff, so it would make no difference what level.

* * * * *

Q. Who does the performance evaluations for the rehabilitation assistants?

A. The unit coordinator.

* * * * *

Q. Could you describe for us the role at the facility of the registered nurses? First, I guess I should ask you, how many registered nurses do you currently have?

A. We're required to have six, by contract, so that there is one on each shift, and that's specific to our contract. That—that exceeds the regulations, as far as our license. And, in part, that's because of our location of being not adjacent to any medical facility, it's a guarantee of safety for the residents.

* * * * *

Q. Actually I guess I need to go back and ask you something related to the rehab counselors and assistants about the shifts.

What shift do the rehab counselors work?

A. Primarily first. There's a float rehab counselor on the second that's there for most of that shift.

Q. And what about the rehabilitation assistants?

A. They're distributed over all three shifts, with the smallest number obviously on third shift.

* * * * *

Q. Okay. Now, switching back to the nurses, how many shifts do you have?

A. Three.

Q. Is that 24 hour a day?

A. That's correct, seven days a week.

Q. How are the nurses assigned to the shift?

A. They're—there are—the reason we have six is that allows you two per shift, so that—so that they're, by overlapping the two schedules for seven days you'll have one on shift, or one on each shift, each day, so you have the RN's, a minimum of three RN's in the building, per day, one on each shift.

Q. What are the responsibilities of the nurse assigned to each shift?

A. Well the primary responsibility is that they are the—kind of the senior medical person in the building

all the time. We have medical services provided by both doctors and psychiatrists, but they're only in the building a limited time.

So, they are responsible for any kind of medical services, such as medication, physical health, ensuring that people are—if there are problems with—uh, they even work with—uh, can work with the dietitian if there are special diets for some of our people, might be running special tests on people because of the imbalance in their diet or there's a medication issue.

So again they're the primary medical provider for most of the shift. For second, third, and weekend shift, they're also designated as the building supervisor. And that means that they are responsible for kind of overviewing the coverage in regard to first of all just basic safety, and then if there are special activities or needs in the building, by a particular resident, that they have that responsibility.

We tried to centralize that because it was impossible to do it with four different units, and not having someone coordinate building coverage. You need someone that really has—is looking at all the resources within the building, to see what's needed and when you may in fact need to call in additional staff because you're short-handed or you may have minimum coverage, but you may have a situation where you have a particular high unit, but they're just sort of up and possibly agitated and you want additional coverage.

Q. Do you have any other medical staff that the registered nurses supervise?

A. The LPN's who do a lot of the medica—the medication services. Most of our residents are on numerous medications, and they—more than we had ever anticipated when we set the program up.

And I think that was the reason that we needed to be sure that we had adequate nursing coverage was because of the—the complexity of that medication.

Q. What are the nurses, registered nurses responsibilities with respect to the LPN's?

A. Uh—to ensure that they are—that the medications are passed at the right time to the right people. And that all—if there's any documentation that's required in any events, that it's carried out properly. But the nurse—the RN's have the primary responsibility.

* * * * *

Q. You mentioned that on second and third shifts, and on the weekends, the RN's are the building supervisor?

A. That's correct.

Q. Okay. What responsibilities do they have in that position?

A. Primarily to ensure that there's adequate coverage to carry out and maintain safety in the building, carry out the activities.

Q. Do they have any responsibilities for scheduling staff, that is creating work schedules?

A. Not prior to that. Theirs is more of a response to when we become short-handed, if they need to call in additional staff to ensure that we have adequate coverage.

Q. Do they have—do they have the authority to call in additional staff if—

A. Yes.

Q. —somebody doesn't show up for work?

A. Yes.

Q. So they could call, if I understand you—well, do they—do they have the authority to call somebody and say, "We need you, report to work"?

A. The—the way the system is set up, is we attempt to get voluntary people, maybe someone who will stay over from an existing shift.

Uh—I believe this last weekend we had some people come in early and some people stay late, so that there was nobody—maybe no one who worked actually a full extra shift.

We try to use as many least intrusive ways of setting this up as possible. But they can then go throughout and call people to come in.

I don't think we've actually had a point where we've had to order people. We've generally been able to find people who volunteer or are willing to stay over.

Q. Have there been instances, that you know of, where the nurse in charge of the building had to call somebody at home to ask them to come in?

A. Oh, yes.

Q. Okay.

A. We have a particular situation, when we have bad weather, because of the location, and we have developed a list of local people, in the immediate area who were—were willing to—to come in, so that we are able to call folks who could get there.

Because, if you are outside the immediate area you sometimes can't get in over the mountains.

Q. What other authority does the building supervisor have with respect to the employees?

A. That—that is their primary responsibility.

Q. Suppose that an employee became insubordinate or unruly, or say, you know, showed up for work intoxicated, would the nurse have any responsibility to correct that situation?

A. She would—uh, be required to report that immediately to probably that person's supervisor, and determine what the best action is to take, whether the person be asked to leave the building at that point.

During second shift, first and second shift, on weekends and during second shift, you have at least one counselor in the building as well. So they're—they would be involved if it was their unit, for example.

So, again, you have that other level of staff involved if an incident occurred.

Q. As the building supervisor, what—how is the authority allocated between her or him, if you have a male nurse, I don't know if you do, and an employee's immediate supervisor, whoever that may be?

A. As far as the coverage issues?

Q. Well as far as the kind of disciplinary issue I just mentioned?

A. Well, again, anybody that's—that's aware of that situation would report it. Uh—it would then effect coverage, probably, so the RN would become involved as to whether that person had to leave and whether that would require additional personnel replacement.

Q. As between the building supervisor and the employee's immediate supervisor, who would have the ultimate authority to determine what to do about that employee, in the situations I've posed for you?

A. The building supervisor would be making the judgment, because they would be best able to tell whether the person was intoxicated, for example, if that was the issue.

Q. How frequently do the six RN's have the building supervisor responsibility?

A. By description of that authority, it's second and third shift. It's essentially any time that there's not senior staff or administration in the building.

So even though second shift—uh, generally there will be a unit coordinator or myself or someone in the building, they may—they—you know, we may check on that.

But it is—it is the latter part of second shift, third shift and the weekends.

* * * * *

Q. And my question is, how frequently would any one individual nurse be assigned to the second or third shift or * * * weekend shift—

A. I don't—I don't have figures on how often it happens. But anytime it drops below the—the minimum coverage, they're authorized to—to get the extra coverage.

* * * * *

HEARING OFFICER MORTON: So you got a nurse—two nurses who work only first shift?

THE WITNESS: Right.

HEARING OFFICER MORTON: Okay. And so they are never building supervisors?

THE WITNESS: On weekends they are.

* * * * *

HEARING OFFICER MORTON: Okay. And then but the third shift are always building supervisors?

THE WITNESS: Right.

* * * * *

CROSS-EXAMINATION

BY MR. SCHULZ:

Q. Let's stay with the nurses first. Who decides how many employees are necessary to cover a shift?

A. There's a minimum coverage amount that was set—uh, I think probably a year ago.

Q. And who set that?

A. Uh—it was done with the clinical coordinator and the two unit coordinators.

Q. And so these building supervisors, they wouldn't be responsible for saying that that staffing level is insufficient?

A. It's—well they would determine from—I mean the numbers are already there. So they, by counting the number of bodies in the building they can determine whether or not it's—

Q. Right. But could they—could they decide that that staffing level that was set was inadequate and that they need two—

A. For situational issues—

Q. —additional employees?

A. —sure.

Q. And how would they go about doing that, then?

A. Then they would—they would call the person on call and ask for additional approval.

Q. In what circumstances? Maybe I'm getting confused here. Could they increase the staffing level that's being authorized by the unit coordinator on a permanent basis?

A. Not—No. I mean that would be a change in policy. I mean they would have—They would have to have input and go through a procedure to do that, yes.

But they can situationally ask for an increase. For example, if we have a problem where we need special supervision of a —of a resident.

Q. How often does that happen?

A. Does not happen frequently. It's been—

* * * * *

Q. All right. You talked about the hypothetical of the intoxicated employee showing up. And you said that the building supervisor would use the judgment to determine whether or not that person was intoxicated.

Who would decide whether or not that person should be discharged?

A. Discharged?

Q. Discharged?

A. You mean fired?

Q. Fired?

A. That would go through normal personnel action. The—the building supervisor, or anyone else who observed that, would document—

Q. And report?

A. — what they had seen, and would report it, and it would go up through the same personnel policy—or I mean the disciplinary action that you'd have for anybody else.

Q. But could the nursing building supervisor—

A. Discharge directly?

Q. —discharge directly and say—

A. No.

Q. Or send them home and say "You're suspended," or "You're docked in pay," or anything like that?

A. They—they could send them home if they're not—and then they would—they would call and inform the unit coordinator or their supervisor. If it was a maintenance person it might be the maintenance supervisor, for example.

Q. Okay.

HEARING OFFICER MORTON: Has that ever happened?

MR. SCHULZ: Well that was my next question.

HEARING OFFICER MORTON: Okay. All right. Go ahead.

CROSS-EXAMINATION (CONT'D)

BY MR. SCHULZ:

Q. How often has this ever occurred?

A. No, not to my knowledge.

HEARING OFFICER MORTON: Well, wait a minute.

THE WITNESS: It's not—

HEARING OFFICER MORTON: I can't hear you. I'm sorry.

THE WITNESS:—an occurrence. It's not an occurrence.

HEARING OFFICER MORTON: Never? Are you saying not too much or no?

THE WITNESS: Not to my knowledge has it—

HEARING OFFICER MORTON: Not to your knowledge?

THE WITNESS: Yes.

* * * * *

CROSS-EXAMINATION (CONT'D)

BY MR. SCHULZ:

Q. Okay. We talked about, as I understand it, really what you're gonna run into is situations on weekends and second and third shift, potentially, where they don't have enough people there, for whatever reason, and especially in bad weather?

A. Right.

Q. And that was the problem being addressed by setting up these building supervisor concept?

A. That you needed someone who had ultimate responsibility, to have the authority—to act.

Q. Yeah, to make the head count and to make the telephone calls?

A. That's correct.

* * * * *

Q. Is there a roster that they would check, with phone numbers on it?

A. There's a—there's a schedule. Yeah, they have all the phone numbers. But there's a schedule in each unit that tells who's on each day. So they could check and see if in fact someone's scheduled.

And then sometimes maybe they only have to have them come in early a few hours, just to overlap so that, you know, whatever's necessary can be carried out.

Q. Now, as I understand these—we'll just go through them real quick. These building supervisors, do they hire anybody?

A. No.

Q. Do they transfer anybody?

A. You mean on a permanent basis?

Q. Yeah? Transfer somebody saying, you should be in a different job classification?

A. No. No. The only transfers they would have is if they were moving people from one unit to another to ensure coverage.

Q. To ensure coverage?

A. Right.

Q. To make sure the head count is there?

A. That's correct.

* * * * *

Q. —on any particular shift? How are the LPN's assigned to their job slots? How do they—

A. The nursing coordinator schedules them in on —so that we have adequate coverage. But the—the number was not determined by contract like the RN's.

Q. Okay. How many LPN's do you currently have?

A. Three.

Q. And does the nursing coordinator also coordinate the shifts of the RN's?

A. Yes.

Q. And what do the LPN's do differently that what the RN's do?

A. Well the—the idea of having the LPN's was to have them primarily pass the medications, because that—it is time consuming, and not a good use of the RN time.

Uh—in the—in the original contract, I don't think, again, people had appreciated how complicated that

was. So we made sure we had LPN's available to do that.

Q. Now who do the LPN's directly report to?

A. The nursing coordinator.

Q. The nursing coordinator.

* * * * *

MR. MILLER: Was [Union Exhibit Number 1] something that was reviewed and approved by you or anyone else in upper management before—

THE WITNESS: I was aware that this had been handed out, yes. As I said, it was attached, at that time—

MR. MILLER: No objection.

THE WITNESS: —to the minimum coverage numbers.

HEARING OFFICER MORTON: The exhibit's received.

(Whereupon Union's Exhibit Number 1 was

received in evidence)

CROSS-EXAMINATION (CONT'D)

BY MR. SCHULZ:

* * * * *

Q. —and if they were involved in activity that perhaps wasn't appropriate that they could be subject to an unusual incident report by whoever observed whatever activity they may have been engaged in?

A. That's correct.

* * * * *

Q. —who would ultimately decide whether or not that report or information you're getting is accurate? Who would do the –

A. The ultimate decider?

Q. Yeah?

A. It would be the—it would be the unit coordinator, because they're the supervisor of the whole team.

* * * * *

Q. And you also testified, I believe, the RN's at times will run—

A. Some special—

Q. —groups?

A. —groups that have medical basis, generally.

Q. To their expertise?

A. That's correct.

* * * * *

Q. Okay. Identify the people that would be involved in reviewing these plans?

A. It would be nursing staff, could be the assistants, could be the unit coordinator.

* * * * *

HEARING OFFICER MOTION: On the record.

EXAMINATION

BY HEARING OFFICER MORTON:

* * * * *

A. I take it back, we did assign RN's specifically to units, so that they are more aware of those particular residents. I'm sorry.

* * * * *

Q. Okay. Are they—are the units divided up between the two RN's on each shift?

A. That's my understanding.

Q. Okay. So what—now what—what if—what if there's only one RN on a shift, does that person have responsibility for the two units—

A. Yes.

Q. —that aren't hers?

A. Yes. The primary part is that there—there's a medical component to the treatment plan that they need to be responsible for, and to assist in setting up that part of the plan, and particularly if it has to—uh, that's sort of an interface with the psychiatrist or the medical doctor, the nurse is the person who assists in making sure there's—again, we've had people on special diets, or who would have to watch their fluid intakes or whatever, it's the nurse that provides that information.

* * * * *

Q. Okay. Now, Alicia Cook is the nursing coordinator. Who does she report to?

A. To me.

Q. Okay. And where is she in the structure with respect to the clinical coordinator?

A. That was a joint position previously. It's now—we established a new position for the nursing super—nursing coordinator. There still is a clinical coordinator position.

Q. Okay. But are they—are they kind of equal—are they peers?

A. Essentially.

Q. All right. And what are—what are Ms. Cook's duties, briefly?

A. I'm sorry?

Q. What are her duties, briefly?

A. Supervising nursing and all medical services. She also helps coordinate our—uh, the psychiatric and medical services. She works with our medical doctor, and is capable of carrying out some of those medical activities as well.

Q. And what job classifications, that we've been talking about here today, does she supervise?

A. The RN's and LPN's.

Q. Okay. And does she—does she hire them?

A. Yes.

Q. With—and is she the person who schedules them?

A. Yes.

* * * * *

Q. Is this grievance procedure that you talked about written anywhere?

A. Yes.

Q. Okay. If I were a counselor and I wanted to initiate the first step, who, according to the policy, who would I go to?

A. The counselor for—

Q. I'm a counselor.

A. For your own grievance?

Q. Right.

A. I mean this is what you are grieving?

Q. Correct.

A. It would go—it would go to your supervisor. It would be a written—

Q. And who would that be?

A. Your unit coordinator.

* * * * *

Q. Okay. So I want to talk a little bit about the RN's. What are the hours for first shift?

A. Three—or, excuse me, 7 to 3:30.

Q. Second shift?

A. 3 to 11:30.

Q. Okay. And then third shift?

A. 11 to 7:30.

* * * * *

Q. Okay. One of the reasons I asked this is I know, I think in response to Mr. Miller's question, you were talking about when this—these building supervisor duties begin. And you were saying later in the second shift.

So about what time in the second shift would the nurse—would these other people be gone and the nurse would become the building supervisor?

A. As generally would be somewhere probably around five or six o'clock, that's—that when most of your senior staff would be out of the building.

* * * * *

Q. * * * I mean how does she know when she actually takes over those duties, during her shift?

A. Well, unless you've got a unit coordinator, if there's anything to do with coverage issues, it—it would probably go to her anyway, because that's the person you would ask.

In other words, if I'm in the building, I would, you know, be surprised if they came up to me and said, "Looks like we're gonna be a little short on night shift, what do you think we should do," in other words, that question is going to be asked of the building supervisor.

Q. Okay.

A. Though often times they don't know that for sure until later in the shift, because call-ins sometimes don't occur until maybe an hour or two. So I mean they may not even know that there's an issue that they need to deal with until later in the shift.

Q. Okay. What if—what if there are two RN's on this shift, what's the—what's the Employer's policy about which of them acts as the building supervisor?

A. There has not been a formal policy.

Q. Do you know how that actually works?

A. Just one sort of assumes the responsibility, they'll—

Q. I mean, do you know?

A. No.

* * * * *

Q. Okay. In addition to the memo here, and I understand that there's another memo, is there a job description like the other job descriptions that we've seen here today for this job building supervisor?

A. No, there is not.

Q. Okay. Do they get extra pay?

A. No.

* * * * *

Q. Okay. Do you know—do you know of any instance where they have ever required someone to come in, under threat of discipline for instance?

A. I don't know. But I don't know that it's not happened either.

* * * * *

Q. I mean does the nurse have the authority to do that, say if you don't come in you're gonna get three days off or you're gonna get a written warning or—

A. No.

Q. No. Okay. Maybe someone—maybe someone asked you this, but are you aware of any incident where a building supervisor has ever had to send someone home?

A. I don't—no.

* * * * *

Q. Quickly, on Alicia Cook, as I understand, and I think I heard you correctly, she hires the RN's?

A. Alicia Cook is responsible for that, yes.

Q. And she's also responsible if there has to be a termination, to fire, she's responsible?

A. Yes.

Q. Okay.

A. I mean she's—she is like a department head—

* * * * *

Q. Okay. Let me see, just a couple more. You mentioned somebody being on-call, who is on-call?

A. A member of senior staff is on-call.

Q. Is that a designated individual?

A. Yes, there's a schedule put out on a monthly basis.

Q. Okay.

HEARING OFFICER MORTON: And who is the senior staff? Who are you talking about?

THE WITNESS: Senior staff are those individuals, are the department heads or the unit coordinators, in other words—uh, the people that you went through the exempt list, primarily Peggy Mason, myself, the two unit coordinators, Alicia Cook, Eddie Jacobs, Deb Beverly—

HEARING OFFICER MORTON: Okay. Thanks.

THE WITNESS:—Nathan Fugate. I think I got everybody.

* * * * *

HEARING OFFICER MORTON: Mr. Miller, do you want to call your next witness.

MR. MILLER: Call Alicia Cook, please.

HEARING OFFICER MORTON: Raise your right hand.

WHEREUPON,

ALICIA COOK

A witness herein, after being first duly cautioned and sworn, was examined and testified as follows:

* * * * *

DIRECT EXAMINATION

BY MR. MILLER:

Q. What is your name?

A. Alicia Cook.

Q. Where are you employed?

A. At Caney Creek Rehabilitation Complex.

Q. What position do you hold there?

A. Presently, nursing coordinator.

* * * * *

Q. Okay. Can you tell us who the current nurse is or nurses who are assigned to third shift?

A. We have Sherri Cook, she's an RN; and we have an LPN, Danny Blair. We have a float—uh, between second and third shift, an RN, Toni Hall, she is on third at least four days of the—of the week, four to five.

Q. Who is that?

A. Toni Hall.

Q. Okay. And on the days she's not on third shift does she work at all?

A. She's on second shift.

* * * * *

Q. Now do either Ms. Anderson or Ms. Noble have any building supervisor responsiblities?

A. When they're the RN for that shift, they're responsible for those duties.

Q. Okay. Are there times when both Ms. Anderson and Ms. Noble are there on second shift or is it just—

A. Yes.

Q. —either one or the other?

A. There are times that both of them are there.

Q. Okay. When they're both there, who has the responsibility as building supervisor?

A. Though there's not a formal—uh, responsibility as far as which one is responsible, it tends to be the one who is the most senior. Uh—Toni Hall and Karen Noble came the middle of December. And so they're new employees.

* * * * *

Q. Are there occasions when they [Carlene Hogs, Betsy Smith, and Sondra Robinson] have building supervisor duties?

A. On the weekends they would, and on the rare occasion that they might cover another shift, but—

Q. How frequently do those three nurses work weekends?

A. On the day shift, for first shift?

Q. Yes?

A. Every other weekend.

Q. Is that normally just one day or both days of the weekend?

A. Both days.

* * * * *

Q. Have you seen that [Union Exhibit 1] before?

* * * * *

A. I know that there had been a list of responsibility circulated to the nurses. I heard it verbalized but I had not seen the document.

* * * * *

Q. Are you aware of any instance when a nurse who is the shift—I'm sorry, the building supervisor, had to call anybody to get them to come in or to cover a slot, has that come up since you've been in the position?

A. Not since I've taken the position, no.

* * * * *

CROSS-EXAMINATION

BY MR. SCHULZ:

Q. On the staffing, are there always two RN's present at the facility?

A. On the third shift there is not always two RN's present.

Q. Every other time?

A. Uh—yes, on the other shifts.

Q. On third shift, when there is not always two present, how often does that happen?

A. Two RN's or two nurses?

Q. Either way?

A. Because we have an LPN on that shift as well.

Q. Right.

A. Uh—one to two times a week—uh, given that there is holiday season or—uh, that it's a time that a lot of residents are gonna be out of the building.

HEARING OFFICER MORTON: There's just one RN, is that what you're saying, one or two times a week there's just one RN on third shift?

THE WITNESS: Uh—occasionally one, one time a week.

* * * * *

HEARING OFFICER MORTON: Do you have another witness, Mr. Miller?

MR. MILLER: Mark Stone.

WHEREUPON,

MARK STONE

A witness herein, after being first duly cautioned and sworn, was examined and testified as follows:

HEARING OFFICER MORTON: Okay. Have a seat. Speak into the microphone. Go ahead, Mr. Miller.

DIRECT EXAMINATION

BY MR. MILLER:

Q. What's your name?

A. Mark Stone.

Q. Where are you employed?

A. CCRC.

Q. That's Caney Creek?

A. Caney Creek Rehabilitation Complex.

Q. What position do you hold there?

A. Unit coordinator.

Q. For which unit?

A. A and B.

Q. Who do you supervise?

A. I supervise direct care staff, which is the 20 RA's and 10 rehab counselors.

Q. And what do you mean by RA?

A. RA is short for rehab assistant.

* * * * *

Q. Okay. Mr. Echols testified earlier, I believe you were here when he testified, about the summaries that the rehab counselors prepare?

A. Yes.

Q Now, what's in those summaries?

A. Summaries is to determine where they're at, as far as progress made towards goals in their treatment plan. I mean the facility is treatment plan directed.

So if the treatment plan—uh, tell somebody they have hygiene problems or whatever, then, you know, the responsibilities of the assistants and—the responsibilities of the counselor is to make sure the assistants carry this stuff out.

* * * * *

MR. SCHULZ: Yes. I'd like to call Alice Anderson.

WHEREUPON

ALICE ANDERSON,

A witness herein, after having been first duly cautioned and sworn, was examined and testified as follows:

HEARING OFFICER MORTON: Okay. Have a seat there. And like I'm telling everybody, just kind of talk into the mike there. Go ahead, Mr. Schulz.

MR. SCHULZ: All right.

DIRECT EXAMINATION

BY MR. SCHULZ:

Q. Please state your name for the record.

A. Alice Anderson.

Q. And by whom are you employed?

A. Caney Creek Rehabilitation Complex.

Q. And for how long?

A. A little over 19 months.

Q. And in what capacity?

A. Registered nurse.

* * * * *

Q. So when you're working there, on second shift, where does your responsibility range?

A. I always have another nurse with me.

Q. Okay.

A. It's either an RN or and LPN. And we—she takes half the building and I take half the building.

Q. Is it always the same or will it vary?

A. It will be either an LPN or an RN who—

Q. Okay. But will you take the same half of the building?

A. Sometimes we rotate so we can keep up with the residents.

Q. Okay. And who decides on that?

A. Oh, we just say, "You want this side," or, you know, it's just up to us.

Q. Okay. It's just mutual agreement on that?

A. Uh-huh.

* * * * *

Q. Okay. I'm going to show you, I think was called Union Exhibit 1, on the RN Building Supervisor duties. I was going to ask you to look at that document. Do you know what that document is?

A. This was a memo that was put in our memo book. And we had to read it and sign off on it.

Q. All right. Memo book, what's a memo book?

A. We have a memo book with all the memos that come out. And every person in the building is required to read them and to initial a page with their name on it, that they have read this.

Q. Okay. And you saw that—this particular memo?

A. Yes.

Q. Now there was some testimony, just a few minutes ago, about—I think it's—the number escapes me.

HEARING OFFICER MORTON: Well here, let's get them.

Q. Employer's Exhibits 13 and 14. I'd like you to take a moment or two just to look those over. And then let me know when you've finished looking them over.

(Pause)

A. I remember Carol talking to us about these, but I don't recall seeing them, but—

Q. Okay.

A. —they could have been in the book and I just overlooked them.

Q. Okay. You don't remember them?

A. No.

Q. All right.

A. But I know we did talk about that.

* * * * *

HEARING OFFICER MORTON: No. Well, let me ask you this, is there anything in there, listed in those memos, that you don't do?

THE WITNESS: I don't check the staffing pattern and I don't visit the unit to check coverage.

HEARING OFFICER MORTON: And then go—look it over and see—

THE WITNESS: I'm not in charge of rehabilitation staff. I was never told I was in charge of them.

* * * * *

DIRECT EXAMINATION (CONT'D)

BY MR. SCHULZ:

Q. Who advised you on what your responsibilities of building supervisor was to be?

A. No one. I just read the memo.

Q. You just read the memo. How do you know when you are building supervisor?

A. Of the evening, like when the administration leaves, is that what you're asking?

Q. Well, yes?

A. We usually go up there and look out in the parking lot and see if their cars are gone, and then we know they're gone and—

Q. Nobody comes and tells you—

A. No.

Q. —you're now in charge?

A. No.

Q. All right. Between the two of you that are always on that shift, is there one of you all that decides to be building supervisor or do you both fulfill that function?

A. We both say we're building supervisors.

Q. All right.

* * * * *

Q. Okay. Do you have any relationship with the LPN's?

A. We work together as a team.

* * * * *

Q. So—Okay. I think I've got it. No let's jump back over to this building supervisory. As I understand it from earlier testimony, there was some talk about making calls or asking people to stay over. Can you tell me how that's worked in your practical experience?

A. We usually do not have to call someone from home to come in. But there have been occasions that we've asked people to stay, and they didn't want to.

And so if I thought I was gonna have to call somebody, I would ask Mark or Fred that used to work with us, and before I even ask somebody to stay over a couple hours I call them.

Q. Okay. You call them, and you would be calling them where?

A. Or whoever is on-call. At home.

* * * * *

Q. Okay. Now just briefly—and as briefly as you can, describe what your job duties are, in your position, that you hold?

A. When I come on, it's time for me to start the medications. And so I pass the medications at 1700 and 2100. And it takes over two hours to do the 2100 meds. I do physical assessments. We have eight residents assigned to us. They're all from different units.

I have to do their physical assessments. I take care of any complaints they have, such as stomach ache or maybe a cut or shaving cuts, just whatever they have, I—that's what I take care of. If it's something I can't handle, I call the doctor.

* * * * *

Q. Anything else you do?

A. Uh—if they go on a home visit, they are supposed to come and tell us when they leave or when they return to the facility. It happens sometimes that they don't do that, and we don't even know they're back.

* * * * *

Q. Okay. And do you have any responsibility for making calls?

A. If we don't have enough coverage, I would call the on-call person, and tell them. And then we would see who could possibly come in.

* * * * *

CROSS EXAMINATION

BY MR. MILLER:

* * * * *

A. We had a problem where the—the aides and the counselors were making the calls to the doctor. And only a registered nurse can take a doctor's order over the phone. And we had discussed that.

And she had stated that she was going to have to put out a memo so that they would know not to call the doctor theirself. Dr. Dinady, our psychiatrist, was getting calls from everybody. And he only wants to talk to the nurse.

Q. Okay. When you're working on second shift, as the building supervisor, are you the senior person there?

A. Yes.

* * * * *

A. We were told—I had been there 19 months. We've had three different supervisors. Our first supervisor, and it's never been changed, had told us, "RN's and LPN's are the same at Caney Creek."

* * * * *

Q. And so the LPN should do what you direct to her to do?

A. In some cases. Now she may have more expertise in some area, she has worked in a nursing home, that she might know more, and I would yield to her.

Q. But if there's a disagreement between the two of you about what ought to be done—

A. I would call my supervisor.

Q. Who is your supervisor?

A. Alicia Cook.

* * * * *

THE WITNESS: No. Uh—we don't go to each unit when we come on duty, to check and see if every-

thing's okay. And the only time we know anything about the staffing pattern is if someone calls in they have to come through nursing, or one of the RA's or counselors will come over and say, "We're short," somebody's left, they got sick, that's—that's when we know that we're short.

Q. When you're short, the—it's reported to you?

A. Yes.

* * * * *

Q. You've never had to call anybody to come in?

* * * * *

A. It has never arisen. We've called—I've called them to ask if I can keep someone over, but never to call someone in from home.

* * * * *

EXAMINATION

BY HEARING OFFICER MORTON:

* * * * *

Q. Okay. So, there was some discussion here today, earlier, about authority to discipline people or send them home or—have you ever had to do that?

A. No.

Q. As the building supervisor?

A. No.

Q. Okay. Have you ever had to call either someone on-call or one of the other supervisors, with an employee problem?

A. No.

* * * * *

DIRECT EXAMINATION

BY MR. SCHULZ:

Q. Please state your name, for the record.

A. Ben Martin.

Q. And by whom are you employed?

A. CCRC.

Q. And that's Caney Creek?

A. Right.

* * * * *

Q. But I just want your best recollection of how long you've been there?

A. Approximately almost—I think in April it will be two years.

Q. Okay. And in what capacity are you employed there?

A. Explain.

Q. What's your job title?

A. RA.

Q. The rehab—

A. Assistant.

Q. Okay. Rehab assistant.

A. Uh-huh.

* * * * *

Q. Do you have any relationship, in your job duties, with the RN's or the LPN's?

A. Yeah.

Q. And what would—tell me how you all interact?

A. If we have a resident—once again, I work second, and the counselors are gone. And if we have a resident really acting out I will go to the nurse or the RN's and say, this is what's going on, and we communicate that way. And we—we got together and we'll say well—they'll say, what do you think, and I'll say well—you know, it's kind of like back and forth.

And then they usually—uh, either medication or something like that.

Q. Okay. So any other way you interact with the RN's?

A. I'm friends with all of them.

Q. I understand. But not—not on a social basis, but on a business basis? I don't mean—your job duties, that you would have occasion, you said when you have a—

A. Yeah, because if one of them is feeling bad, I mean you'll actually see a resident, you know, just slouching around, I'll actually go the nurse, you know, bring that up to them.

Or, if you see a resident, you know, they'll actually come up to you—they'll come up to me before they will anybody else, and they'll say "My stomach's hurting, I'm not really feeling well," I will actually go, you know, to the nurses, and pull them, and say, do something for it.

Q. Okay. So you communicate to them—

A. Right.

Q. —the medical conditions—

A. Right.

Q. —that you think would need to be taken care of?

A. Uh-huh.

Q. Any other ways you interact with those people?

A. We help them get them up for meds, when the medication comes around.

Q. Okay.

A. We get them all out and bring them up.

Q. So when the nurse needs—

A. Right.

Q. —some assistance you do—

A. We do that.

Q. —that?

A. Uh-huh.

Q. Any other way that—I mean, you know, that you can think of, that's kind of a regular part of your job that you're gonna have to interact with them?

A. Besides medications, I guess what we call PRN's, we actually go in with the nurses when they do that.

Q. What is that?

A. It's sort of like if a resident is really acting out, like a medication to—to, you know, bring them back, to stabilize them.

HEARING OFFICER MORTON: That stands for "As needed"?

THE WITNESS: Yeah.

HEARING OFFICER MORTON: Yeah.

THE WITNESS: We actually go in and make sure everything goes fine with that.

MR. SCHULZ: Okay.

DIRECT EXAMINATION (CONT'D)

BY MR. SCHULZ:

Q. Provide some assistance—

A. Assistance—

Q. —security, whatever—

A. —yes.

Q —you want to call it?

A. Right. Security and assistance.

* * * * *

Q. Okay. Oh, who's your immediate supervisor?

A. Mark Stone, Treatment Coordinator.

* * * * *

PROCEDURE: For Building Supervision

RATIONALE: To facilitate Caney Creek Rehabilitation Complex's operation during the time when Administration is not available in the facility

During the time that Administration is not available within the facility, a nurse will be designated building supervisor. This includes evenings, nights, weekends, holidays, and weather emergency situations. He/she will be in charge of the facility and all rehabilitation staff. All concerns of the building, staff, staffing, and residents will be first directed to the nurse in responsible for quality resident care. He/she will take call-offs, ensure adequate staffing, and be ultimately responsible for quality patient care. Staff will be responsible and accountable to the building supervisor. He/she will assume leadership in emergency situations. He/she, or his/her designee, will make all telephone calls, including those to administration. This establishes a chain of command and will eliminate unnecessary and duplicate phone calls.

[Emp. Exh. 13]

MEMORANDUM

DATE: August 23, 199€

TO: All Nurses

FROM: Carol Sincaglia

SUBJECT: Building Supervision

Mr. Echols and I discussed that you as building supervisors are not being utilized enough. We will have this issue on the agenda again at Monday's Senior Staff meeting. In the meantime when you come on duty, please check the staffing pattern and visit the units to check the coverage. If necessary, pull from one unit to another. Please write up anyone who does not comply with the request immediately. This will give you more visibility in this role.

[Emp. Exh. 14]

R/N-BUILDING SUPERVISOR
DUTIES

In absence of the Administrator, Assistant, or Treatment Coordinators, the R/N on duty will assume the responsibility of Building Supervisor. In the event of an emergency the R/N-Building Supervisor will follow the procedures identified in the emergency plan.

In the event of Inclement Weather (Snow, Flood) and employees are unable to drive to work the R/N-Building Supervisor will call local employees first (A list of employees attached with local employees highlighted), all calls will be made from CCRC. R/N-Building Supervisor will have the authority to ask employees to stay over until they have a replacement or there are 5 employees per wing plus a security guard.

Every effort will be taken to relieve the R/N-Building Supervisor and employees in the earliest possible time frame fitting the emergency situation.

The R/N-Building Supervisor is not relieved of his/her duties until an Administrative person, Administrator, Assistant Administrator, or Treatment Coordinator, is in the Complex.

[Union Exh. 1]

REQUEST FOR PROPOSAL
Cabinet for Human Resources

Eighty (80) Bed Personal Care Home
For Adults with
Severe Mental Illness

Knott County, Kentucky

Prepared by:
Department for Mental Health and Mental
Retardation Services
May, 1994

[Jt. Exh. 4]

* * * * *

SECTION 30
SCOPE OF WORK AND PROGRAM REQUIREMENTS

30.000 Purpose

It is the purpose of this RFP to obtain the contract service of a single entity to accomplish the following:

A. Operate and manage an eighty (80) bed personal care home in Knott County, Kentucky for persons with severe mental illness;

B. Provide psychiatric treatment and therapeutic rehabilitation interventions that are appropriate for adults with severe mental illness;

C. Provide directly or through community resources, opportunities for residents to gain and/or improve basic living skills;

D. Maintain the quality of care and services in accordance with 902 KAR 20:036 personal care home operation and services, and in a manner acceptable to the Cabinet for Human Resources as defined in this RFP.

30.100 Mission and Programmatic Design

The eighty (80) bed personal care home is established with the mission of providing an environ-

ment for the rehabilitation and support for persons with severe mental illness. The majority of the individuals will be referred directly from the state psychiatric hospitals, others with an extensive history of psychiatric hospitalization may be accepted for admission from the community upon the review and approval of the interagency, screening committee. The personal care home is designed to provide rehabilitation and treatment in a residential setting for individuals who require a structured and supervised environment. Mental health treatment and rehabilitative programming will be designed to assist residents in managing their mental illness and in acquiring basic living skills.

Residents of the personal care home should be assisted in retaining the fullest possible control over their own lives and be empowered to make choices concerning the services and activities in which they will be involved. The services available should be culturally appropriate and based on a psychosocial rehabilitation model where staff work with residents, individually and in small groups to assist them in acquiring or strengthening skills. Examples of skills residents may need include: (1) meal preparation; (2) housekeeping; (3) laundry; (4) basic reading, writing and math; (5) use of public transportation; (6) money management; (7) social skills; (8) self-management, and others as determined by the resident's goals and functional assessment. Recreational activities, both in the facility and in the community, should be integrated in the daily and weekly routine offered to residents.

The facility should be staffed by capable, qualified, culturally sensitive individuals who demonstrate knowledge of and commitment to the concept of psychosocial rehabilitation. The atmosphere and attitude should be one of staff support, resident empowerment, respect and positive regard for the individual. The focus of all actions will be to protect and balance the rights of the residents and to provide an environment that maximizes opportunities for acceptance. Services will be provided in accordance with the principles of normalization.

30.200 Description of Target Population

The facility shall serve those individuals eligible for receiving personal care home services as specified in 902 KAR 20:036 and who meet the following criteria:

Adult men or women who have been discharged or are awaiting discharge from a state psychiatric hospital, can be referred to the personal care home.

The individuals who will be considered for admission may have experienced failed placements, (community or alternate care facility), multiple inpatient psychiatric admissions and/or long tenure in a state psychiatric hospital. While not all of the individuals referred will have a history of the following behaviors, the personal care home is designed for persons whose behaviors are challenging to treat and require a more intense level of individualized intervention. In a study of the

reasons why individuals return to state psychiatric hospitals, the following behaviors and conditions were noted as contributing to unsuccessful placements:

- socially inappropriate behaviors (physical acting out towards others; sexually inappropriate behavior; setting fires; etc.)
- wandering or running away from previous living situations;
- a lack of assistance with resource management;
- a history of depression which may include suicidal attempts;
- substance abuse and mental illness;
- poor use of leisure time;
- unwillingness or inability to seek treatment/rehabilitation services for psychiatric problems which result in uncontrolled psychotic behavior;
- poor personal hygiene to the extent that interferes with contact with others.

30.250 Screening and Admission Process

Individuals will be screened by a committee, including representatives of the Department for Social Services, the Community Mental Health Centers, the state funded psychiatric hospitals, the vendor organization and a consumer. The Division of Mental Health will serve as an ad hoc, non-voting representative. For individuals, referred to the facility, the admission criteria shall be im-

posed which considers those who are in most need of services. A draft copy of more detailed admission criteria is attached. (See attachment B.) Any exceptions to the use of this process would have to be approved by the Commissioner of the Department for Mental Health and Mental Retardation Services.

If an individual is referred to a state psychiatric hospital for the 80 Bed Personal Care Home and is discharged within two weeks, he/she shall be allowed to be directly re-admitted to the personal care home.

30.300 Bio-Psychosocial Assessment, Functional Assessment, Treatment/Rehabilitation Planning, Documentation and Discharge/ Aftercare Planning Requirements

The vendor shall comply with the following Bio-Psychosocial Assessment, Functional Assessment, Treatment/Rehabilitation Planning, Documentation and Discharge Planning Requirements:

Bio-Psychosocial Assessment

All services shall be provided as identified through an individualized bio-psychosocial assessment which is developed by the resident and clinical team of the personal care home. The personal care home shall initiate services beginning with a self-assessment by the individual which identifies his/her preferences, personal goals and needed services. The bio-psychosocial assessment shall be completed within 30 days of admission and shall cover each of the following areas:

— A physical examination within 14 days prior to admission for individauls who come directly from the state operated or contracting psychiatric hospital, a physical examination performed within 30 days of discharge from a state psychiatric hospital is acceptable;

— Information related to the following:

  — Home and community environment;
  — Religion;
  — Childhood history;
  — Military service history;
  — Financial status;
  — The social, peer group, and environmental setting from which the person comes;
  — The person's family circumstances, including the composition of the family group; the current living situation; and social, ethnic, cultural, emotional, and health factors, including drug and alcohol use.

— An assessment of emotional, and behavioral status and substance abuse use;

— A nutritional assessment, including special diets, eating disorders or any major weight changes;

— Based on the permission of the individual, a determination of need for the involvement of the family members or other individuals with

whom the resident has a significant relationship in the resident's treatment/rehabilitation;

— Information describing relevant past and current legal status;

— A mental status examination and current psychiatric evaluation; (A mental status examination and psychiatric evaluation performed within 30 days of discharge from the state hospital is acceptable.)

— An educational and vocational history;

— A history of medications and their side effects as experienced by the individual;

— An assessment of whether and physical and/or mental health problems are life threatening or may seriously affect the treatment or rehabilitation process.

Functional Assessment

A functional assessment shall consist of the identification of skills and skill deficits of the resident. (See attachment C functional assessment form to serve as as example of this requirement.) The following broad skill areas should be considered when developing a functional assessment:

- Time management;
- Health management;
- Social/recreational skills;

- Basic Living skills;
- Vocational/educational skills;
- Interpersonal relationship skills;
- Money management.

Each assessment shall be individualized for each resident.

Treatment/Rehabilitation Planning

Within 30 days of admission, a comprehensive treatment/rehabilitation plan shall be developed from the data contained in the psychosocial assessment and functional assessment. When indicated, a specific plan for involving the family or "significant others" with the permission of the resident, should also be included. At least annually, the individual shall receive the following: a physical examination; a dental examination; a psychiatric evaluation and updated functional assessment. The treatment/rehabilitation plan should also include:

- Language that is understandable to the resident's level of functioning;

- Goals related to the functional assessment, as well as crisis intervention/stabilization and clinical needs as determined in the psychosocial assessment (i.e., person's presenting problems, physical health, emotional status and behavior status);

- Objectives that are specific, measurable, observable, and time-limited;

- Staff who are assigned to work with the individual and frequency of treatment/rehabilitation interventions;

- The strengths of the individual;

- Evidence of involvement of the resident through each of the following:
  1. person's signature on the treatment/rehabilitation plan and;
  2. personal expression of rehabilitation goals, personal comments or suggestions for treatment/rehabilitation plan;

- Services outside the personal care home necessary to meet the resident's needs;

- Discharge criteria identified and agreed upon by persons listed on the treatment/rehabilitation plan.

Treatment/rehabilitation plan reviews and documentation of such shall occur under the following conditions:

- Every 3 months, and

- During major changes in the person's condition.

Progress Note-Documentation

The progress notes should clearly document the service delivery process. Charting should occur at least once weekly and at times when there is a significant change of behavior. The notes must contain the following:

- Dates(s) of service;

- Notation of services rendered and progress toward achievement of treatment/rehabilitation goals;

- Resident's reaction to treatment/rehabilitation interventions and need for continued treatment.

Information about the treatment/rehabilitation services provided by outside resources should also be included in the chart, if the individual agrees to the information being obtained and signs a release of information.

Discharge/Aftercare Plan

Upon discharge from the residential facility, an aftercare plan will be sent to the provider who will offer continued services. The aftercare plan will contain the following:

- Admission date

- Date of transfer

- Reason for transfer

- Condition at transfer

- Assessment
  1. Significant findings
  2. Progress
  3. Final assessment

- Recommendations
- Resident and family response
- Evaluation of current status

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